Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Doncaster & Bassetlaw Hospitals NHS Foundation Trust

1.1 Operational Plan for y/e 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

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Date	3 April 2014

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Chris Scholey

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Mike Pinkerton

Signature 

Approved on behalf of the Board of Directors by:

Name *(Director of Finance & Infrastructure)*	Matthew Lowry

Signature 

1.2 Executive Summary

Strategic Context and Direction

Doncaster and Bassetlaw Hospitals NHS Trust (DBH) recently developed our *Strategic Direction 2013-17* which identifies our vision to be recognised as the best healthcare provider, consistently performing in the top 10% nationally. To achieve this we have outlined four strategic themes:

- Provide the safest, most effective care possible
- Control and reduce the cost of healthcare
- Develop responsibly, delivering the right services with the right staff
- Focus on innovation for improvement.

We have a good track record of delivering high quality care in line with national targets and continue to maintain our market share in the Doncaster and Bassetlaw communities. Our operational plan for 2014-16 describes how we intend to deliver appropriate high quality and cost effective services for our population over the next two years in line with our strategic vision and themes.

This two year plan is part of the five year strategic plan and we have engaged with, and will continue to engage with, the wider local health economy to develop our operational and strategic plans. We have other supporting strategies to enable the implementation of the *Strategic Direction 2013-17*and these include the People & Organisational Development Strategy, the Dementia Strategy and the Research & Development Strategy. There has been a specific focus on research & innovation in service level plans. We are also reviewing our capital plan for the next 5- 10 years.

Our commitment to quality remains our primary driver and delivering harm free care is our highest priority. We have actively implemented a review of care in line with the recommendations from the Francis and Keogh reports. We have a very detailed action plan with actions against each of the recommendations. We have identified our approach to quality in our plan and provided details on the actions required to maintain quality standards for 2014-16.

We recognise that DBH will need to adapt and transform to meet the changing needs of the population, further accommodate the integration of care and the increasing centralisation of specialised services. This two year period is also unique in terms of the "affordability challenge" including the introduction of the Better Care Fund (BCF). The implementation of the BCF will create challenges and opportunities. The scale of the financial resources transferring to this fund equate to £24m for Doncaster & £8m for Bassetlaw. We have the opportunity to continue to work with our partners to provide the right care in the right place for our populations. We have already commenced this work and have nationally recognised integrated discharge services and are actively engaged in the BCF planning discussions.

Set against this funding backdrop we have additional challenges that include implementation of seven day working to improve quality and the recruitment of staff to deliver evidence based staffing levels in line with the *Safer Nursing Care Tool (SNCT)*[1]. We need to ensure that this investment, alongside effective utilisation of other resources, provides opportunities in terms of patient experience, reduced length of stay and implementation of BCF schemes so that we can reduce our inpatient footprint whilst continuing to meet national compliance targets such as Referral to Treatment (RTT) and the 4 hour access target.

In order to deliver this reduction we will also need the co-operation of our commissioners and community partners to deliver reductions in demand for emergency and elective care. We have worked with the non-elective Intensive Support Team (IST) to establish accurate demand & capacity planning and robust bed and workforce plans.

The Trust's Financial Plans have been developed alongside the other elements of this Operational Plan to ensure alignment of key assumptions and drivers.

[1]Safer Nursing Care Tool, Implementation Resource Pack; the Shelford Group, 2013

Successful delivery of the financial plan for 2014/15 will see the Trust delivering a 1% operating surplus (£3.5m), with a 1% uncommitted contingency and a month end cash balance in excess of £9m throughout the planning period. This translates to a Continuity of Services Risk Rating (CoSRR) of a strong 3.

The income position included in the plan reflects the contractual settlements reached with commissioners. Contract settlements have been informed by detailed activity projections undertaken by the Trust, to highlight the activity levels required (both recurrently and non-recurrently) to maintain, and in some areas improve waiting time performance. Overall, this gives a total planned income of £349.7m, compared to 2013/14 forecast outturn income of £349.5m.

The 2015/16 position reflects the same principles and results in a prudent view of anticipated income of £349.6m, as a result of tariff deflation, expected activity changes (based upon extrapolation of recent trends), developments, movements in non-patient income. This income assumption is clearly dependent on the success of demand management schemes especially in emergency care with further reductions in emergency activity anticipated.

The 2014/15 expenditure budget is fundamentally based upon the 2013/14 recurrent baseline adjusted to the 2014/15 price base and capacity levels aligning cost with activity, contracts and resources. This includes substantial investment in 2014/15 for; inflationary rises, volume allocations in respect of patient activity increases, historic cost pressures and service and capacity developments including the full year effect of 2013/14 schemes and is inclusive of reductions for cost improvement plans. CIP of £14m in total is included in our plans for 2014/15. This equates to 4.7%.

Capital expenditure of £19.2m in 2014/15 and £20.2m in 2015/16 is planned. This is less than the £21m forecast outturn for 2013/14, but remains higher than historic levels. The key areas of investment are identified within the plan.

The key financial risks for next two years identified within the plan are:

1 – CSU/directorate overspending
2 – Delivery of the required savings
3 – Commissioner affordability / success of demand management

Key to the mitigation of a number of these risks is the quality of the plan, with, for example, the adequate funding of genuine cost pressures in CSUs, alignment of expenditure budgets with activity assumptions, 1% general contingency reserve, £2m in-year development reserve and sign off of budgets at Directorate level all key to mitigate the risk of CSU / directorate overspending. The impact of these risks materialising has been modelled and clear mitigation plans are in place.

1.3 Operational Plan

1.3.1 The Short Term Challenge

National and local commissioning strategies continue to provide considerable threats and opportunities for DBH. Our recently developed *Strategic Direction 2013-2017* takes account of our commissioner and partners' strategies and the changing future context of the NHS. The strategic themes identified are:

- Provide the safest, most effective care possible
- Control and reduce the cost of healthcare
- Develop responsibly, delivering the right services with the right staff
- Focus on innovation for improvement.

In line with these strategic themes, we have jointly identified the following short-term challenges for DBH within the local health economy and have worked with our commissioners and local partners to define the extent of these. The seven main short term challenges that we have identified are set out below.

1.3.1.1 Affordability

Rising health care demand, rising costs and flat real funding mean the NHS could face an estimated £30 billion financial shortfall by 2021[2]. This clearly also provides a local impact and we are engaged with partners across health and social care to meet this challenge.

In line with our strategic theme of controlling and reducing the cost of healthcare, and in order to achieve an affordable position, we will continue to work in partnership with primary care providers to manage continued increases in demand. Whilst DBH is an active partner in this process, the sphere of influence is limited by the provision of community services being with another provider, (see 1.3.1.5 below).In terms of specialist commissioning there are similar cost pressures in terms of affordability of increasing chemotherapy drug costs and increasing activity.

The implementation of the Better Care Fund will create challenges and opportunities. The scale of the financial resources transferring to this fund equate to £24m for Doncaster and £8m for Bassetlaw. From 2015/16, there is also the challenge that half of funding is performance-related.

Working with key stakeholders and partners as part of the local health economy to address this challenge and others is fundamental to providing appropriate, high quality and cost effective services. In addition to the strong relationships we have with our commissioning, community and local authority colleagues we have also formed a partnership with seven other trusts in South Yorkshire, Mid Yorkshire and North Derbyshire called the "Working Together Programme" (WTP) to share best practice and improve patient care. This is in line with our partnership approach identified in our *Strategic Direction 2013-17*.

To be supported for inclusion the WTP any proposed work will need to demonstrate potential benefits associated with an ability to:

- Create large scale and demonstrate the benefits of scale
- Standardise processes where there is collective benefit in standardisation
- Raise standards, clinical and managerial, to a high/acceptable level
- Manage the impact of scarcity on quality and financial grounds
- Optimise the deployment of intellectual property across all partners
- Optimise the use of physical property across all partners
- Limit duplication and the associated confusion, effort and cost.
- Manage the paradox of competition and the need to plan and operate with rationality

[2] Monitor's report *Closing the NHS funding gap: how to get better value health care for patients* available at http://www.monitor.gov.uk/closingthegap

- Subordinate organisation preference to user (customer) preference
- Demonstrate a clear ability to add value to an existing collective mechanism

1.3.1.2 Enhancing quality – seven day working

One of the priorities identified in our *Strategic Direction 2013-17* is to transform our urgent care services and provide a 24/7 delivery model. This is in line with both Doncaster and Bassetlaw CCG's priorities for 2014-16 and contributes to all four of the Trust's strategic themes.

We have implemented a project to deliver more robust seven day working arrangements. This started in December 2013 at Doncaster Royal Infirmary (DRI) and we have continued with the seven day working arrangement at the Bassetlaw Assessment & Treatment Centre (ATC). There has been a recent reduction in Hospital Standardised Mortality Ratio (HSMR) especially at weekends. For maximum impact the project implemented seven day working in conjunction with continued improvements to the acute medical pathway, an increase in specialty ward rounds and amendments to the bed plan. Integrated care (including social work input) has also been increased to seven day input with a model where assessment is in the right place at the right time.

In December, we also commenced a local programme called "Working Well This Winter" which has improved patient flow through the hospital. The programme will continue through 14/15 as initial evaluation has shown significant improvements in terms of improved patient flow, enhanced patient experience and more effective use of inpatient services. In January, the Trust was in the top 10% of NHS Trusts in achieving the 4-hour access target.

The next phase of seven day delivery is dependent on recruitment to medical posts including Acute Physicians and Gastroenterologists.

This creates a dual challenge in terms of cost and recruitment and retention of workforce (see below). We already provide a number of services on a seven day basis and the cost associated with the further investment required is £828k, which is a combination of medical staff costs and the cost of enhanced support services and this is provided for in the financial plans.

1.3.1.3 Availability of workforce

There are workforce challenges to enable us to implement the national requirements for seven day working and to deliver evidence based staffing levels in line with the *Safer Nursing Care Tool (SNCT)*[3]. There will be a number of organisations increasing the numbers of substantive nursing and midwifery staff at the same time and this is likely to result in a national and regional shortage of additional qualified nurses and midwives. Therefore, recruitment will be difficult until additional university places increase. The Trust will work with commissioners and partners on improving recruitment, retention and implementing a targeted approach to ensure appropriate workforce plans are in place. It should also be noted that the implementation of the Better Care Fund and a planned reduction in length of stay should provide the opportunity to reduce inpatient bed numbers – as described in section 1.3.3. A reduction in bed numbers will improve the nursing staff to patient ratio and mitigate the risk of inability to recruit.

We have challenges in a number of specialities in recruiting to middle and consultant grade medical posts. Again, these often link to specialities where there is a national shortage. As part of the collaborative "Working Together" programme, we are actively involved in a specific project group called Specialty Collaborative Working Together. This will identify a number of options to provide safe and sustainable models of care, particularly in smaller services – where recruitment can be a challenge, for example, Ophthalmology.

[3]Safer Nursing Care Tool, Implementation Resource Pack; the Shelford Group, 2013

1.3.1.4 Governance compliance targets

Clostridium Difficile – We have continued to deliver year on year reductions in C. Difficile cases. In 2013/14 we have not achieved the Department of Health target of 37 cases but are on trajectory to meet the Monitor target of 48 cases. The draft target for next year is 45. This will reduce even further the limited flexibility in this area, with the vast majority of current cases confirmed through root cause analysis as unavoidable.

Referral to Treatment Targets (RTT) – Both active waiters and non-admitted pathways have achieved the national targets throughout the year. The admitted pathway target has not been achieved but is on trajectory to be achieved from end April 2014 onwards. This will continue to be a challenge unless demand is managed in key areas including Urology, Breast and Colorectal surgery. To mitigate this we are basing our capacity on our own demand modelling (See section 1.3.3).Over the past 6 months the Elective Intensive Support Team (IST) has worked with the DBH Clinical Service Units (CSUs) to put in place robust demand and capacity plans for the Trust to maintain performance for all RTT indicators.

In addition, data quality has been reviewed and we are confident that there are rigorous processes to identify patients at all stages of the pathway. This work will continue into the next planning period and is a key stream of the PAS replacement process in June 2014.

4 hour Access Targets –The Trust has achieved the quarterly targets this year and has been in the top 10% of trusts nationally for achievement of the target in January. However, this remains a challenge and we are actively engaging with the Emergency Care Intensive Support Team (ECIST) and local commissioners to implement best practice.

1.3.1.5 Reliance on other healthcare partners to manage demand on services in line with commissioning intentions

DBH do not provide the majority of community services in either Doncaster or Bassetlaw. The Trust is therefore dependent on partners to assist with management of demand, reduction in admissions and readmissions and subsequently avoidance of the financial penalties that apply to these. At month 9, the Trust incurred penalties of £689k for emergency admissions over 08/09 levels and £4.4m for readmissions over the agreed baseline. We predict a year end impact of £5.8m.

Commissioners have reinvested a large proportion of this income to support schemes to address emergency pressures. However, this is a non-recurrent funding source so it is vital that we mitigate the risk this presents. Therefore, we will continue to scrutinise admission and readmissions data to identify themes and opportunities to work in partnership with community healthcare providers, on specific key pathways such as the frailty pathway, respiratory pathway and paediatric pathways. We recognise that reducing unnecessary admissions and re-admissions also has a benefit to patients and allows us to provide the safest most effective care possible whilst controlling the cost of healthcare, in line with our strategic objectives.

Our Executive Team also actively contribute to the Doncaster Health & Wellbeing Board, Integrated Care Board at Bassetlaw, and respective Urgent Care Working Groups. This engagement and commitment ensures that we remain a proactive member of the local health economy, making changes to the way we work to provide care in an integrated way in the right place at the right time.

In keeping with the strategic theme “develop responsibly, delivering the right services with the right staff”, we will continue to extend our work into community settings. We will develop our community based market share through responding to tenders and opportunities for diversification, where a model of vertical integration would provide clinical and efficiency benefits and improve experience for patients. We have been successful in the tendering process in a number of areas this year, including extending our Tier 3 weight management services to children as well as adults in Doncaster and providing a new model of community and hospital

based Cardiac Rehabilitation in Bassetlaw. This proactive approach will continue throughout the next 2-year planning period and beyond.

We will also work together as one team across the communities we service and further develop our partnerships with commissioners, local authorities, acute trusts, voluntary, community and independent sector to continuously improve care and drive down costs.

1.3.1.6 Better Care Fund (BCF)

We have existing strong relationships within the local health economy including CCGs, other providers and local authorities in the Doncaster & Bassetlaw area. We have a history of working together to provide integrated services consistent with the national conditions identified in the Better Care Fund guidance. An example of this is our Doncaster Rapid Access Process Team (RAPT) which was cited in the Keogh Report, which works as part of the Integrated Discharge Team providing a joint approach to assessment and care planning over seven days a week. We will build on these relationships and shared successes with the implementation of the BCF that provides unique challenges and opportunities, specifically in 2015/16 and 2016/17.

One of the main risks created by the BCF is the scale of the financial resources transferring to this fund which equate to £24m for Doncaster & £8m for Bassetlaw. From 2015/16, it is also a concern that 50% funding is performance related. It is therefore vital that we are actively engaged in discussions around performance criteria and achievability. The Integrated Care Board at Bassetlaw and Intermediate Care Board at Doncaster are monitoring the potential impact of the Better Care Fund. The initial Doncaster BCF funding for schemes directly managed by DBH is only circa £100k, however, many schemes required to support admission avoidance and discharge are being funded and that will have a positive impact on demand, patient flow and length of stay for example, supported discharge for stroke, Older People's Mental Health Liaison services, single point of access.

To mitigate the above risks and to achieve the transformational requirements we have co-operated fully with our local authorities and commissioners in development of the BCF plans. In Doncaster this is through active participation as a member of the Health & Wellbeing Board. At Bassetlaw, there is a different approach given the geographical size that is covered by the local authority and DBH contributes to the Bassetlaw Locality Implementation Group – which feeds into the Nottinghamshire Health & Wellbeing Board.

Bassetlaw Board is one of the 3 locality areas for the Nottingham County Council funds. The Board has delegated authority for local decision making and 5 key areas are being addressed each lead by a local provider:

- Elderly care
- Urgent Care
- Mental Health
- Post-acute Care
- Care Homes.

The Doncaster Better Care Fund will focus on five similar areas seeking benefits in:

- Delayed transfers of care
- Emergency admissions – unplanned care
- Effectiveness of reablement
- Admissions to residential and nursing care
- Patient service/user experience.

These measures plus an additional locally agreed measure will form the basis of the performance related payment component of the Better Care Fund finance arrangements. Doncaster Council's partnership with Sheffield Hallam University will provide academic rigour to these and additional measures for the Better Care Fund scheme.

A key aim of the partnership is to avoid hospital admissions and provide community based acute hospital avoidance services and comprehensive integrated rehabilitation and reablement services. This has a clear potential impact on the future shape of services provided by DBH. There is a need for further modelling to agree the impact in detail. However, it is expected that there will be a focus on providing efficient high quality planned care services, a responsive A&E, acute emergency services and the development of capacity and capability to manage older people who are frail and have an increasingly complex clinical need.

It is expected that during the next 5 years, there will be a 15% reduction in non-elective activity and a significant improvement in planned care productivity. In terms of implications for 2014-16, the transition to a community focussed patient offer requires some parallel running of services. This will be achieved using non-recurrent resources as the transition takes place.

There will be the opportunity to work at a health community level with partners to roll out seven day working across Health and Social Care Teams, with the focus on integration. There is a focus on discharge from DRI, bringing together nursing and therapy staff from our service, with RDASH, and associated social care teams, aligning services to form an Integrated Discharge Team incorporating Rapid Access Process Team, Community Intermediate Care Team, STEPS, Assessment Beds and Care Homes.

The next phases of work will assess the ability of those services and teams to cope with peaks and troughs in demand and to assess whether they have the appropriate skill mix to deliver a seven day service. Another positive impact for patient flow in DBH will be the planned assessment of the availability of other services on a seven day basis including community equipment services, medical and pharmaceutical services, hospital transport and other community based services.

1.3.1.7 Maintaining & Delivering Specialist service profile

Being in a position to maintain and deliver our current specialist service profile is in line with all four of our strategic aims. However, DBH provides a number of services that could potentially be at risk due to the lack of critical mass and the move to centralise services into significantly fewer providers than the current model. Services at risk include: bariatric service, vascular and interventional radiology. In terms of specification compliance and derogation Specialised Vascular (Adult) and Severe Complex Obesity are classed as having commissioner derogation due to the complexity of the provider landscape and service review is likely to follow. This situation replicates that for other providers in the region. Being unable to provide these services would not only affect the individual service that is at risk but the other services where there are interdependencies. We are providing services that meet and exceed quality standards for Vascular and Bariatric services and we want to work with our commissioners to ensure that these quality services remain available to our local population.

The following specialised services meet the specifications and will be included in the mandated section of the 2014/15 contract with NHS England:

- Renal peritoneal dialysis
- Renal dialysis – hospital & satellite
- Acute kidney injury (adult)
- Neonatal critical care
- Implantable aids for microtia, BAHAS and middle ear implants.

Service specifications classed by as B3 (amber), which means that they have an action plan to achieve compliance with the specification by April 2014 include Chemotherapy (Adult) and Renal Assessment (Adult). These will remain in the development section of the 2014/15 contract – the SDIP. In 2014/15, we will work closely with commissioners to provide evidence that the action plans have been implemented in year.

DBH provides chemotherapy for haematological oncology and also provides satellite services for patients requiring solid tumour chemotherapy who are under the care of consultants employed by Sheffield Teaching Hospitals NHS Foundation (STH). This enables the provision of chemotherapy services close to home for people who live in Doncaster and Bassetlaw. We are currently undertaking joint planning with our STH colleagues for the future delivery of chemotherapy services to ensure effective use of capacity. Our Pharmacy services are already implementing outsourcing to control and reduce the cost of healthcare in line with our strategy. We will continue to work closely with NHS England embedded Pharmacists and other local providers to develop dose banding and vial sharing to reduce costs further.

We are continuing to develop our strong outline case for the development of local radiotherapy services, in conjunction with our partners at STH, and will work closely with commissioners to make this a reality.

One of the five areas of the Working Together Programme is Specialised Service and we will be working with our partners and NHS England commissioners to help configure services across the partnership to meet the very demanding service specifications and to offer safe consistent care in all locations.

The impact of commissioning priorities and BCF priorities are summarised in Appendix 1.

DBH will respond to the threats and opportunities provided by local commissioner intentions by:

- Continuing to deliver our *Strategic Direction 2013-2017*
- Working in partnership and collaboration with commissioners and other providers (see section 1.3.1 above)
- Responding positively to market tenders and the AQP programme
- Diversifying our services for growth and sustainability
- Delivering our iHospital Programme
- Working with commissioners to identify solutions which will allow scalable cost solutions to offset income changes
- Strengthening our clinical service unit structure and supporting managers and clinicians to improve forecasting, develop robust demand and capacity plans and service retraction plans in response to reduced demand
- Implementing the recent review of our corporate governance.

1.3.2 Quality Plans

Supported by our partners and commissioners we believe that high-quality care is efficient care, and that quality is the organising principle on which services will be based. The provision of high quality care within the Trust will be characterised by openness, transparency and candour; with ourselves, our patients and our commissioners and regulators.

In the development of our *Strategic Direction 2013-2017* the Board of Governors stated:

- We want a uniformly high standard of patient experience from our first contact with the patient when they are referred to our services, through to providing transport options and car parking amenities, up-to-date entrance and reception facilities and modern, clean, fit-for-purpose outpatient and inpatient accommodation
- Where possible, we want patients to have a choice of when and where they receive their care and be provided with easy-to-understand information about the services, their treatment, and aftercare and how they can stay healthy
- We want staff to be developed and trained to deliver the highest standards of clinical care whilst being friendly, honest, compassionate and polite to patients, visitors and their colleagues
- When patients have to stay in the hospitals, we want them to be cared for on the correct ward and for them and their relatives to be kept well informed about their diagnosis and treatment. When diagnosis or treatment is needed urgently, we want appropriate care provided, irrespective of the time of day or day of the week

- When patients are ready to go home, we want discharge at a reasonable time with their medicines ready to take home and clear instructions on any follow-up care. We want good liaison with primary care to ensure a smooth transition to their services, if required
- We want patients to be highly satisfied with the care provided and if care ever falls short of this, it should be straightforward to comment or complain
- We expect lessons to be learnt from feedback across the whole organisation and that good practice is spread and sustained.

To implement the above and to provide the safest most effective care possible the priorities in the Strategic Direction 2013-17 are being implemented and this includes:

Developing our systems that identify patients at risk so staff can respond promptly and take appropriate action – We will ensure the recognition and appropriate management of patients at risk by building on the work we have undertaken to improve the use of Early Warning Scores in Adult and Paediatric services and the management of sepsis.

Taking a zero tolerance approach to avoidable infections and implementing annual plans for mortality reduction – We will maintain progress on the delivery of infection prevention and control measures, building on the significant progress that has been made through 2013/14 (see section 1.3.1.4 above). In addition, we will continue the detailed pathway and coding work to ensure the delivery of the Mortality Reduction Programme and utilise the new clinical structure to go further faster with the development of 24/7 delivery models.

Ensuring our staff display the highest professional standards in everything they do – Key to our success in providing quality care is the engagement of our staff and we will build upon the award winning People and Organisational Development work to ensure high professional standards and effective clinical practice is consistent across our organisation.

Delivering our duties in safeguarding children and vulnerable adults – We will revise the Trust Safeguarding Strategy to improve the delivery of Adult and Child Safeguarding

Ensuring we deliver the care basics for older people on our wards – We will continue to work with our commissioners and partners to build upon the award winning Integrated Care Pathways work to enhance the care of older people and secure discharge to assess processes.

Aligning our CQUINs proposals to better support safe and effective care and make a positive contribution to health promotion and preventing disease – We will continue to work with commissioners to use CQUINs (Commissioning for Quality & Innovation) to deliver innovative solutions to the delivery of care, maintain health and prevent disease. The main challenges generated by the CQUINs are reflected in the priorities below.

Involving patients in decisions about their care, enhancing patient experience, welcoming feedback and learning from complaints and compliments – Through our new Complaints, Concerns, Comments and Compliments policy we will enhance the use of patient and public satisfaction to drive changes in the way in which we provide services.

Whilst we have made good progress in implementing our priorities, we recognise that a number of areas are not currently achieving the levels of performance we are seeking and key actions for 2014/15, which will be reflected in the 2012/13 Quality Report, are:

1. Ensure the delivery of the National Quality Boards guidance on Nurse Staffing; Building on the Trust Boards commitment to evidence based staffing levels we will utilise the *Safer Nursing Care Tool (SNCT),* to identify the correct staffing levels and workforce plans for all our ward areas. However, we recognise that a risk to this plan is the availability of additional qualified nurses and midwives nationally and recruitment will be difficult until additional university places increase and the Trust will work with commissioners and partners to ensure appropriate workforce plans are in place. This is identified as one of the short-term challenges for DBH in section 1.3.1.

2. Continued improvements in HMSR and SHMI for weekday and weekend admissions through the work which is being undertaken to improve pathways of care and the accuracy of clinical coding.

3. Implement the revised Tissue Viability Strategy to achieve a reduction in the number of Hospital Acquired Pressure Ulcers (HAPU) to ensure a 10% reduction in the rate of HAPU. Working with our commissioners, and utilising CQUINS we will purchase additional equipment and introduce revised procedures to ensure that all patients who require admission to hospital are on the correct tissue viability pathway within 4 hours arrival at hospital.

4. Reduce the number of procedures cancelled on the day of admission. Recognising the distress and disruption that a cancelled procedure has on our patients we will aim to reduce the number procedures cancelled on the day for non-clinical reasons to 0.7% as an internal target. This will be linked to a theatre scheduling project and bed plan for splitting out elective beds. We will also set a target of reducing clinical cancellations to 5% in light of the implementation of the new processes for Preoperative assessment; this will be linked to iHospital work.

5. Implement the *Dementia Strategy 2013/2017*; Working with our commissioners, and utilising CQUINs we will continue the award winning work on Dementia care to introduce additional Dementia Friendly wards and facilities and improved assessment and pathways of care to the community.

6. Implementation of the revised Complaints, Concerns, Comments and Compliments policy; Utilising the opportunity to learn from our patients experience we will improve the way in which we use all types of feedback to reduce the number of formal complaints received and improve the quality and timeliness of our responses

We have actively implemented a review of care in line with the recommendations from the Francis and Keogh reports. We have a very detailed action plan with actions against each of the recommendations. The Francis Report Action plan update is presented to the Clinical Governance Standards Committee (CGSC) and to Trust Board on a quarterly basis and will be reviewed for 2014/ 15. Our Business Intelligence Report is organised around the Keogh actions and is reported to the Board Monthly with additional reporting on specifics, including staffing levels.

The CQC reports from the assessments in October were checked against the existing action plans to ensure that there were no gaps and no new actions were added. This is reflected in the Board, Management Board and CGSC minutes.

Two of the priorities identified in our *Strategic Direction 2013-17* were supporting the Clinical Directors and their teams to make the right strategic and operational decisions and developing clear rules for managing performance and ensuring people are accountable. In the 2013/14 annual plan, an external review of corporate governance structures and processes was identified as an action. This review was undertaken in 2013 and following this process robust plans are being implemented to further enhance our governance processes and the Board assurance of performance. These plans include:

- Review of committee structures to ensure a greater separation of operational delivery and assurance roles
- Further strengthen existing risk management processes and structures
- Streamlining the Clinical Service Unit (CSU) structure by aggregation into a smaller number of management units; and
- Strengthening the process for reporting back to the Board by its sub-committees.

The process to streamline Clinical Service Unit structures has already commenced and will be concluded by July 2014. The revised structure will create a smaller number of CSUs with a standardised structure and will:

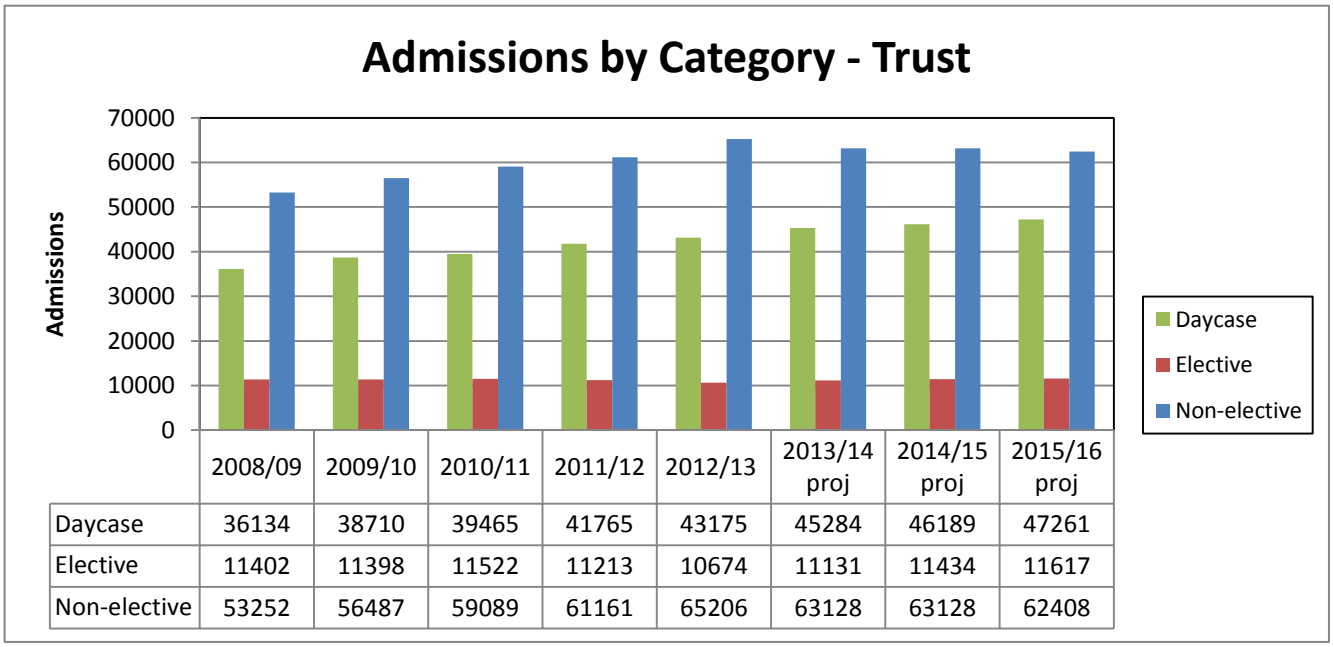
- Be built around patient pathways
- Make sense for patients and encourage teams to work together, across team boundaries
- Enable better outcomes for our patients

- Be more effective and efficient
- Provide more support for leaders to make good decisions and get things done
- Support investment in key Trust wide priorities whilst contributing to the savings required
- Support the growth and sustainability as a Trust
- Ensure broad equivalence of roles across Care Groups in terms of responsibility, complexity, staff numbers and budgets
- Provide a framework for staff development and succession planning.

1.3.3 Operational Requirements and Capacity

Demand Profile & Activity Mix

The following graph indicates the historical trends in admissions for day case, elective and emergency admissions with 13/14 being based on a projection from Month 10. Projections for 14/15 and 15/16 are also included.



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14 proj	2014/15 proj	2015/16 proj
Daycase	36134	38710	39465	41765	43175	45284	46189	47261
Elective	11402	11398	11522	11213	10674	11131	11434	11617
Non-elective	53252	56487	59089	61161	65206	63128	63128	62408

Elective and Daycase

Throughout 2013/14 we failed to achieve the 90% admitted RTT targets in six specialities. After extensive review of waiting list management and implementation of action plans, four of these specialities, Oral Surgery, ENT, Ophthalmology and Gynaecology now have sufficient capacity internally to meet demand and have sustainable waiting times. ENT will meet demand within current capacity, Ophthalmology and Oral Surgery are planned to have one additional theatre list and Gynaecology will lose one list and this will be transferred to Trauma and Orthopaedics.

Colorectal surgery failed to meet the RTT target due to increased demand on the 2 week wait pathway. Operating demand can be maintained within current theatre capacity; however, outpatient capacity needs to be increased by 3 outpatient clinics per week. This requires capital work to be undertaken in the Outpatients Department, which is planned for March 2014.

Over the past 12 months the consultant workforce in General Surgery has seen 10 new appointments and this instability had a negative impact on productivity. The new team will become established throughout 2014/15.

Trauma and Orthopaedics continues to be reliant on private provision of circa. 1000 cases per year and a contractual arrangement for this will remain in place for 2014/15.

Over the past 6 months the Elective Intensive Support Team(IST) have worked with the CSUs to ensure that robust demand and capacity plans are in place in order for the Trust to maintain performance for all RTT indicators in 2014-15 and going forwards. In addition, the data quality of the waiting lists has been extensively reviewed by the Elective Intensive Support Team (IST). The IST has now signed the Trust off as having a robust and compliant waiting list that ensures that planning is accurate.

Demand Planning Assumptions for 14/15 and 15/16

As part of the capacity and demand planning process, we have reviewed demand over the past two years to monitor for significant increases and decreases in referral patterns and the effect on waiting times. The capacity plans using the IST model are based on the 85th percentile so allows for flexibility in the system. The capacity work based on 2013/14 referral figures details a number of services which modelling suggests will see an increase in demand which will not be met within current resources. These are mainly due to increasing referrals especially within urology and breast services.

2013/14 has seen an over performance against contract for a number of specialities unrelated to referral pattern but based on historical backlog of patients. The Trust is currently outsourcing general surgery and trauma & orthopaedics procedures due to lack of internal capacity. The plan is to continue with this outsourcing for the remainder of 2014/15. During 2014/15 a review of the impact of 7 day working on internal capacity will be undertaken with a view to repatriating a proportion of this work.

The contract negotiations for elective demand have been based on this year's referral patterns with an overall increase of demand of 2% increased referrals. This is a key area of risk as it will require robust demand management as overall referral rates are higher than this across the majority of specialities. The overall cost of agreeing these referral numbers is £2 million above this year's actual activity and this is a key risk in terms of commissioner affordability. Work is on-going to improve elective productivity, including increasing daycase procedures from elective (especially ENT and Urology), reduction of new to follow up ratios and, daycase to outpatient procedure. Though it should be noted that there is less scope for improvement in the latter as the Trust is already a high performer for this measure. Our capacity plans are based upon this level of activity, with some commissioners not including all this work in opening contract values, although importantly recognising the need to potentially fund this level of activity. Should lower levels of activity be required the Trust will retract capacity in year, minimising the risk to waiting time performance.

Delivery Risks

The key delivery risk is the potential to be unable to achieve RTT. This is particularly in relation to three key pathways: Colorectal, Dermatology and Urology where we have seen major increases in referral rates in 2013/14. There is on-going work to mitigate this risk. The Colorectal pathway is being reviewed alongside improved access to diagnostics. Outpatient capacity needs to be increased for urology and colorectal. A new pathway with increased GP care for urology PSA review is being introduced which will reduce follow ups by 300 cases per year. Dermatology pathways are being reviewed with CCGs with a particular emphasis on referral criteria.

There is a risk that capacity will not be realised as planned if there is inconsistent theatre productivity practice. The Trust has sufficient operating theatre capacity in all areas with the exception of Trauma and Orthopaedics. Overall theatre capacity has been calculated and theatre lists moved to specialties in line with respective capacity requirements. Specialities will therefore be managed against their capacity plans to ensure theatre utilisation is maximised on all 3 operating sites, including 4 hour theatre sessions which will form part of the cross cutting theatre productivity programme identified in section 1.3.4.

The day surgery unit opened at Doncaster Royal Infirmary (DRI) in September and the aim is to increase utilisation of this area to achieve maximum efficiency in 2014/15 and 15/16. Key to this increase is the installation of the green laser for urology procedures which is planned to be ready for April 2014. This will allow urology day case to be the norm for the majority of procedures undertaken. This will allow 20% of urology procedures to be undertaken as day case. 7 day working within the day surgery unit is also planned to be in place for April 2014. This will allow the flow of procedures for general surgery daycase procedures to be undertaken on Saturdays.

The current bed plan is predicated on splitting elective from emergency work to ensure limited interruption of elective flow. Years 2014/15 will see all elective work on DRI housed within one block. Bed modelling suggests that 16 beds will be available within this block following the transfer of work to the day surgery unit. This is part of the overall bed plan that has been agreed by the Trust Board. Patient flow generally will be considered as part of the Site Development Plan currently being undertaken.

Diagnostic waits have been maintained with the exception of MRI, which has year on year seen an increase of referrals. The service currently operates 7 days a week 12 hours a day. An additional mobile scanner is currently being utilised twice a week to maintain the 6 week diagnostic wait. A business case is being developed to have a second scanner at DRI in 2014/15.

In addition to the above, in order to address recurrent and non-recurrent demand the following requirements are being addressed.

Workforce Requirements

The key 3 areas where workforce has been an issue in managing demand are in Gastroenterology, Urology and Ophthalmology:

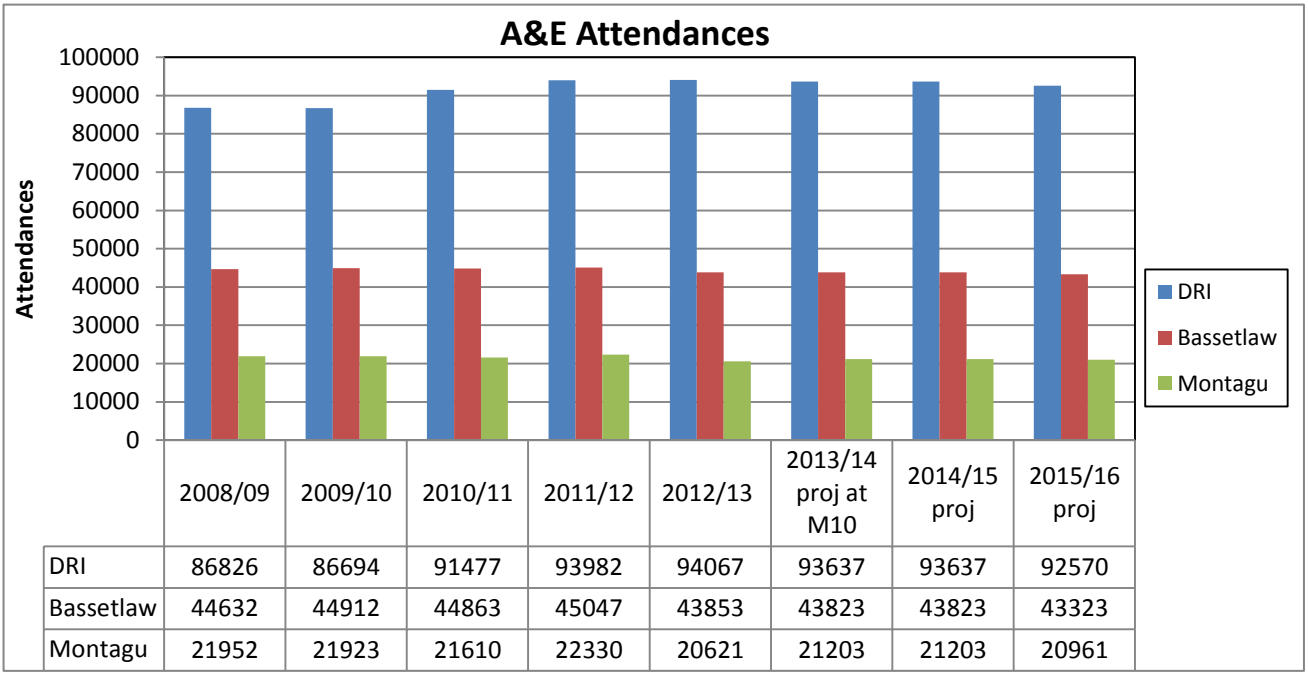
- Gastroenterology – Two consultant posts are being advertised and we are optimistic we will recruit to these substantive posts. In the interim, workload is currently being supported through a combination of agency and additional sessions
- Urology – An additional consultant post is being advertised – this is to address the additional workload and is not a replacement post. Current activity is supported through additional sessions and 3 session days
- Ophthalmology – A consultant post is being advertised, the job plan has been redesigned to make the post more specialised to improve prospects of recruitment.

Environmental Requirements/Physical Capacity

The following actions are planned for 2014-16 to ensure adequate physical capacity and they are all included in the capital plans:

- Additional endoscopy capacity is required and a business case is being undertaken to review overall capacity requirements on each site, as part of the site development plan
- JAG accreditation has been achieved - on the condition that minor works are completed on DRI site
- A theatre business case is in development for theatre capacity on DRI site, including the provision of additional orthopaedic theatres
- Capital work to the Ophthalmology department is planned to increase the size of the department at the same time as redesigning pathways for nurse led services.

Emergency Capacity



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14 proj at M10	2014/15 proj	2015/16 proj
DRI	86826	86694	91477	93982	94067	93637	93637	92570
Bassetlaw	44632	44912	44863	45047	43853	43823	43823	43323
Montagu	21952	21923	21610	22330	20621	21203	21203	20961

The above graph highlights increases in A&E attendances – with 13/14 being based on a projection from Month 10. Projections for 14/15 and 15/16 have been included.

Demand Planning Assumptions for 14/15 and 15/16

The current Trust bed plan is based on the 12/13 activity for all non-elective admissions with no impact taken into account of any reductions in emergency activity or length of stay and is based on an occupancy rate of 87% to allow for usual variations in demand.

2013/14 has seen an improvement in emergency flow through DBH. In December 2013 we introduced the start of 7 day working on the emergency pathway at DRI to match the principles of the Assessment Treatment Centre already established at BDGH in 2011. Senior assessment and decision making from specialities into the ED and early senior planning has improved patient flow both in ED and through the assessment units.

The Trust has worked closely with the Emergency Care Intensive Support Team to review the whole system. Additional bed capacity has been introduced this year on all sites and in the community.
The key priority for both CCGs in 2014/15 is the introduction of frailty pathways across secondary and primary care. The Trust is introducing a frailty unit on the Doncaster site and 17 non reablement beds are being piloted in the community under the supervision of consultant geriatricians.

In 2014/15 length of stay has been identified as a key target for medical specialties. The discharge pathways are being addressed. Doncaster has nationally recognised integrated care, which now works 7 days to improve discharge processes. Nationally Doncaster reports minimal delayed transfers of care. The Trust is working with BCCG and primary care to improve transfer to assess for Bassetlaw residents.

Delivery Risks

We are planning to be able to retract bed capacity in line with the changes to service provision from Better Care Fund, improved community provision, decreases in length of stay and improved seven day working. However, we identify that being able to retract beds and still maintain access targets is a key risk. The plan to remove beds is based on the joint pathways with primary care utilising community bed capacity effectively. This is also a financial risk as the current additional bed capacity is not recurrently funded but has been supported by additional winter funding.

The inability to retract the additional winter medical beds will also impact on other IPC targets as these are designated for use as a planned decant facility.

Doncaster social care assessment beds have been piloted for the past 2 years. 37 beds for social care assessment 25 for non EMI and 12 for EMI have evaluated well in terms of reducing the number of patients transferring directly from secondary care to long term care as well as reduced delayed transfers of care. Doncaster is in the top 10% of Trusts for the number of delayed transfers of care. DMBC has formally agreed to continuing the social care assessment beds which will move to a purpose built unit of 33 beds based at Home Covert.

Readmission rates remain higher than national average in medicine and emergency surgery. The renewed emergency pathways with early consultant review and improved discharge plans will have a significant impact on readmission rates.

Short term service developments likely to impact on capacity in 14/15 and 15/16 include:

- Integrated Crisis response – Creating flexible access services coordinated through a central one point telephone services
- Development of reablement service through a new joint Community Independence Services, reducing hospital admissions and nursing and residential care costs
- Reduce Delayed Discharges
- Build on integrated discharge and Invest in 7 day working, including 7 day GP services
- Avoiding admissions – Strengthening community services that avoid unnecessary hospital admissions
- Home from Hospital Community services – Low level support to reduce re-admissions and support person centred outcomes.

Workforce Requirements

There is a workforce requirement for provision of seven day working. There are challenges in terms of availability of workforce to enable us to implement the national requirements for seven day working and to deliver evidence based staffing levels in line with the *Safer Nursing Care Tool (SNCT)*[4]. There will be a number of organisations increasing the numbers of substantive nursing and midwifery staff at the same time and this is likely to result in a national and regional shortage of additional qualified nurses and midwives. Therefore, recruitment will be difficult until additional university places increase. The Trust will work with commissioners and partners to ensure appropriate workforce plans are in place, (detailed in section 1.3.1.2 above).

We have challenges in a number of specialities in recruiting to middle and consultant grade medical posts. This will be addressed by active recruitment and as part of the Specialty Collaborative Working Together, project.

Environmental Requirements/Physical Capacity

Changes to office space are underway to provide an additional ward which is located in the main block and this will be used to accommodate a bespoke dementia friendly frailty assessment area. This is addressed in the capital plans.

1.3.4 Productivity, efficiency and CIPs

We have defined a robust programme of schemes, totalling £14m, which can improve quality whilst driving productivity. These are a combination of CSU led schemes and cross cutting trust wide schemes. In order to ensure that schemes are deliverable and not detrimental to the quality of patient care, the CSUs have undertaken a Quality Impact Assessment (QIA)for each CIP scheme. Additional steps for assurance

[4]Safer Nursing Care Tool, Implementation Resource Pack; the Shelford Group, 2013

were then followed. This provides a mechanism for peer challenge, cross reference across the organisation and Board assurance.

The assessment process used for QIA was based on assessment of non-financial risk including ***patient safety, clinical effectiveness and patient experience***. The supporting process for this assessment is identified in the DBH Risk Assessment Policy to ensure consistency (Clinical and Non-Clinical) CORP RISK 18 v.2. As most of the schemes actually improved care there was an option where no risks were identified to state "none".

Deliverability was assessed using a RAG rating and the criteria for deliverability are:

- Red – Definite risk of underachievement
- Amber – Some risk of under achievement
- Green – No risk of underachievement.

The Assurance Process used was a 4 step process:

1. All assessments were initially undertaken in the CSU with clinical input where applicable.
2. Assessments were sense checked by the Director of Finance& Infrastructure, Chief Operating Officer and Head of Strategic Planning & Service Development, to ensure that the QIA guidance had been.
3. Review was undertaken by the Director of Nursing and Medical Director to agree schemes – sharing with the lead commissioner took place at this point.
4. A summary of CIP schemes and the associated quality and deliverability assessments was provided to Management Board to provide peer challenge and general awareness of schemes and potential overlap.

All CSUs have been required to submit action plans with identified performance indicators and mitigation for any schemes where there is a risk to quality or delivery. Monitoring and accountability for the implementation of the action plan, impact on safety and delivery of efficiencies and transformation at CSU level will be achieved by review of the action plans and performance indicators at the CSU accountability meetings. This process will be streamlined in line with the review of governance and planned reduction in the number of CSUs.

A full breakdown of the CIP schemes has been generated but the following narrative describes the state of development of a number of key transformational programmes in more detail.

We are aware that improvement opportunities exist by implementing efficiencies in current services within DBH, ensuring the right care is in the right setting and potential provision of new services where either scale or integration provide positive quality and financial benefit.

Schemes identified are therefore a combination of the more traditional CIP schemes and transformational schemes.

Examples of the traditional CIP schemes include:

- Review of skill mix in a number of corporate teams
- Outsourcing of nurse bank
- Savings from increase in substantive staffing and reduction in nursing and medical agency premiums
- Changes to medical records storage (in-house instead of outsourced)
- Implementation of dose sharing and banding in Chemotherapy

Examples of a number of transformational schemes that are already underway and schemes of higher value are detailed below.

Bowel Scope Screening

"Improving Outcomes – a Strategy for Cancer" (published in January 2011) committed to pilots for flexible sigmoidoscopy for bowel cancer screening commencing in 2011/12. The introduction of this new cancer screening programme, for the population reaching age of 55, is called Bowel Scope.
Building on the success of the pilots, it is expected that 60% of Bowel Scope Screening Centres will have commenced by the end of 2016.

Out of the four sites in SYCOM, Doncaster has been chosen as the first to go live in light of our position with regards to Joint Advisory Group in GI Endoscopy (JAG) accreditation compliance. The model will be rolled out in July 2014 for the population of South Yorkshire and Bassetlaw which covers 4 trusts, Sheffield Teaching Hospitals NHS Foundation trust, Barnsley Hospital NHS Foundation Trust, The Rotherham NHS Foundation Trust and our own Trust.

This innovative development is on line with all four of our strategic themes, particularly developing responsibility and delivering the right services with the right staff. The business case has been agreed through our internal business planning processes, activity assurance has been provided by commissioners and recruitment to Nurse Endoscopist posts is currently underway and project plans in place to commence delivery.

This is an exciting opportunity to develop the service in line with commissioners' requirements in a way which provides high quality care in a cost effective and efficient way. Overall this scheme will see income of:

- £600k in 2014/15 and
- £1.6m in 2015/16

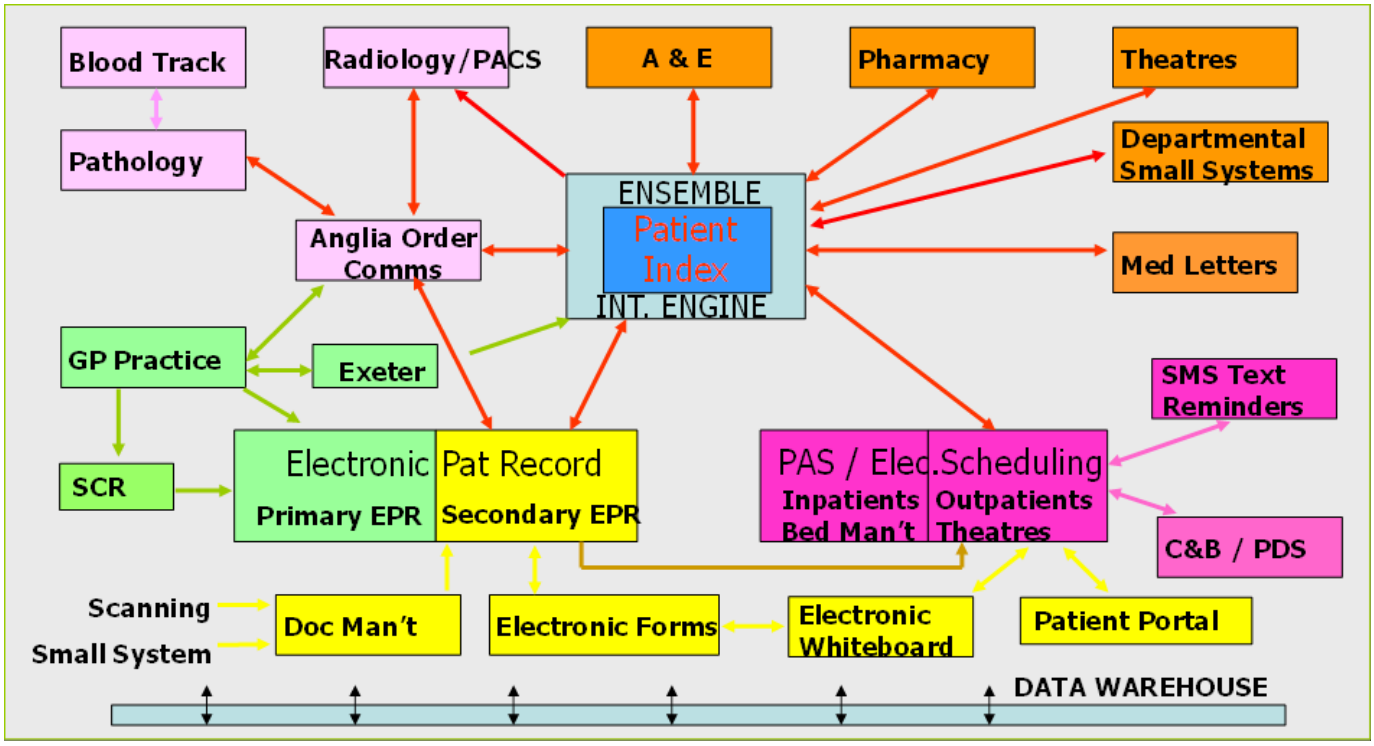
The iHospital Programme

The iHospital Programme has been developed to support patient safety and to facilitate the transformation of the Trust's provision of services through alignment with the key objectives within the *Our Strategic Direction 2013-17* for IT enabled innovation and more effective care.

In addition, the iHospital Programme supports the delivery of NHS England's 2013 most recent initiative "Safer Hospitals, Safer Wards: Achieving an Integrated Digital Care Record" and the Francis Inquiry Report, recommendation 244 for sharing of data through electronic records. Patient Safety lies at the heart of both these drivers for change. The iHospital Programme builds on the successful adoption of E-Prescribing and Order Communications and also addressing the challenges around 'Smart Care' in an increasingly digital world where the patient's participation in their own care programme is supported through everyday technologies.

The implementation is an opportunity to implement highly configurable, up to date technological systems and devices that will re-position the clinical and business processes of the Trust to meet the fast changing health environment in which it operates. This will include for instance the replacement of the current mix of electronic systems and paper records which present risks to providing the safest care possible due to the lack of immediate access to clinical information.

The diagram below sets out the systems architecture of the trust following the delivery of the systems included in the iHospital programme. The Yellow boxes are the additional systems which will provide the trust with an Electronic Patient Record. Note all systems continue to be linked through the Integration engine to share information. Staff will use the Secondary EPR system (Portal) for viewing information from all systems but will move into the best of breed systems where specific functionality is required such as PAS for scheduling patient appointments or PACS for ICE for ordering tests.



The iHospital Strategic Outline Case has been developed and a series of full business cases will go to the board. To deliver the ambitious plan of a 'Paperlight Hospital' in 14/15 and 15/16, the Trust will embark on a programme of work that will consist of phases of work that are completely interdependent and will run in incremental stages but not necessarily in chronological order:

- Phase 1 – Core ICT Infrastructure
- Phase 2 – Clinical Record Viewer (or portal) / system integration
- Phase 3 – Electronic Document Management (EDM) including off site printing
- Phase 4 – Electronic forms and interactive Electronic Whiteboard
- Phase 5 – Replacement Patient Administration System (PAS) and Accident & Emergency System
- Phase 6 – Enhanced data warehouse / reporting tools
- Phase 7 – New Intranet / Internet
- Phase 8 – Integrated Electronic Patient Record (EPR) - cross enterprise data sharing.

The Trust's strategic vision for Information and Communications Technology is focused on enabling the concept of:

- a Trust wide , 24/7 EPR with latest patient information for improved and timely clinical decision making
- real time activity based information on demand that will allow better management of each stage of the patient's journey through the various care pathways and focus on timely interventions giving shorter lengths of stay, minimising re-admissions and higher quality of care
- rules based processes for scheduling activity, clinical pathways, patient centred tasks ensuring greater coordination of planning all aspects of the care pathway
- the effective management of its business activity through real time information for both clinical and process management staff.

The financial impact of this project will be:

- £311.5k in 2014/15
- £420k in 2015/16.

Cross Cutting Transformation Projects - Quality Improvement & Change Team

We have identified funding to develop a bespoke Quality Improvement & Change Team called "We Care – for our future" to strengthen co-ordination, support and accountability for delivery of transformational schemes. Many of the efficiency schemes identified at service line level are common and require coordination at a Trust level and the following strands that will benefit from this approach have been identified as:

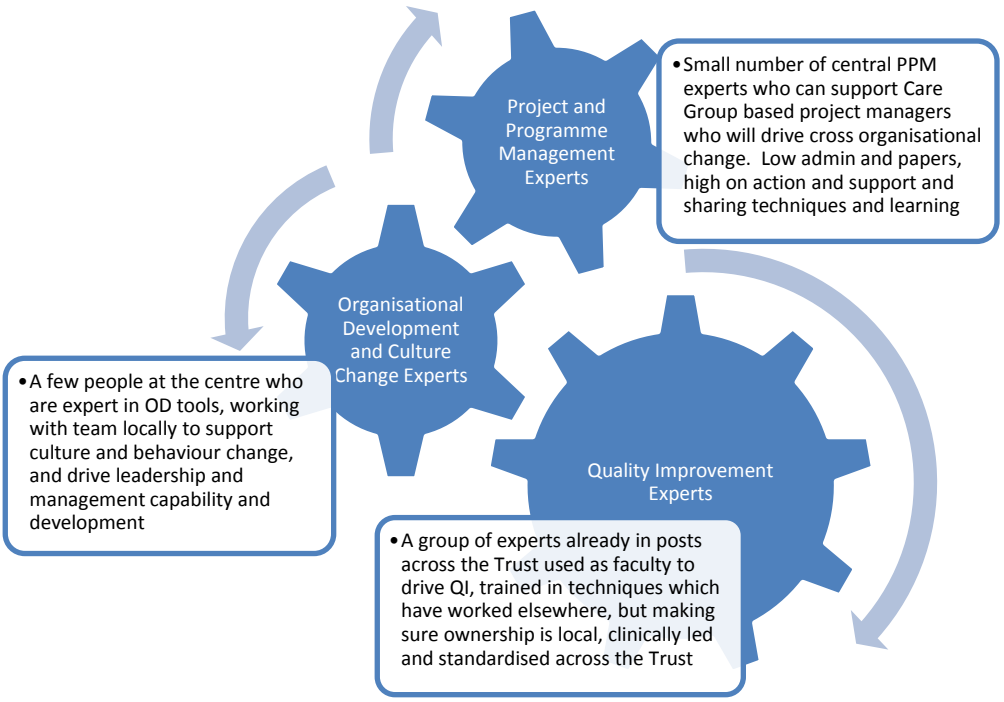
- Outpatients
- Workforce and Culture Change
- Elective Care
- Non-elective care
- Infrastructure

Each of these strands will be led by an Executive Sponsor.

The timescales for implementation have been identified and the initial set up phase will be Feb-March 2014, embedding ways of working April – June 2014 with full implementation and business as usual by July 2014 and beyond.

Achieving our vision of performing in the top 10% will be because we have transformed the way we work across the organisation. We are good at delivering new things within parts of the business, but need to get better at delivering organisational wide change and performance improvement that can be sustained for the future.

This programme is about every group working together across the Trust with the shared understanding that the only future we have is to provide high quality, efficient and effective care. We are proposing that a small team of experts will work with teams to develop and embed the key skills in each group so they can be sustainable, and also lead and manage the overarching programme. The structure is illustrated below.



The financial impact of this project will be:

- £500k in 2014/15
- Additional scoping work required for 2015/16.

1.3.5 Financial Plan

The Trust's Financial Plans have been developed alongside the other elements of this Operational Plan to ensure alignment of key assumptions and drivers.

Successful delivery of the financial plan for 2014/15 will see the Trust delivering a 1% operating surplus (£3.5m), with a 1% uncommitted contingency and a month end cash balance in excess of £9m throughout the planning period. This translates to a Continuity of Services Risk Rating (CoSRR) of a strong 3.

Income

The income position included in the plan reflects the contractual settlements reached with commissioners. Contract settlements have been informed by detailed activity projections undertaken by the Trust, to highlight the activity levels required (both recurrently and non-recurrently) to maintain, and in some areas improve waiting time performance. The level of GP referrals is a key determinant in this modelling, with the trust analysis based upon historic growth rates in referrals over the last 2 years, adjusted for known issues, at specialty level. This equates to c2% further growth for Doncaster CCG for example. Within the contract settlement some commissioners have chosen not to fully reflect this growth pending the future impact of demand management initiatives. The Trust will, however, continue to plan on the basis of the modelled activity levels being required, with the potential to retract capacity that is not required in year representing a much lower risk than the implications of assuming the success of demand management and consequent impact on RTT performance. This will mean that the commissioner's plans and those of the Trust differ (by c£1.8m), although they can be reconciled with reference to the above.

The Financial Plan also reflects non-recurrent commissioner support for 7 day working and ward staffing levels (totalling £1.3m). This is in additional to the limited funding in the tariff (£810k), with the additional non-recurrent funding enabling the Trust to move further, faster on these two key areas in advance of further funding flowing through the tariff in future years.

Further commissioner support has also been agreed to maintain the investments made non-recurrently in 2013/14 in A&E, winter and additional beds. We have also reached agreement on how any future national funding for winter will be invested, with some of this funding effectively underwritten by commissioners to share the risk associated with the continued investment by the Trust in this area.

The Trust also benefits from additional education income in respect of new tariffs for MADEL, NMET and SSLDF totalling £1.1m.

R&D Income of £567k has been identified - an increase on 2013/14 levels of £61k due to new income sources being identified.

There are a number of proposed changes to the Provider to Provider contract values for 2014/15 from 2013/14 totalling a £540k reduction including retractions in relation to; TUPE of services to RDASH (£113k), NLAG retraction of Occupational Health (£175k) and changes to ENT service contract with Rotherham FT (£136k). Plus, recharge income (offset in expenditure) has increased significantly in year due to the expansion of the Pharmacy outpatient drug volume.

Whilst contracting rules for 2014/15 again see the Trust only paid at 30% of tariff for activity over the 2008/09 baseline, the Trust has agreed with commissioners the use of the remaining 70% to support the continuation of the investments made in A&E, winter and beds in 2013/14 referred to above, as in previous years.

Similarly, as in previous years, the Trust's base income position assumes that the level of money which commissioners will be able to deduct for re-admissions is re-cycled back to the Trust. This assumption is shared by commissioners.

This gives a total planned income of £349.7m, compared to 2013/14 forecast outturn income of £349.5m.

The 2015/16 position reflects the same principles and results in a prudent view of anticipated income of £349.6m, as a result of tariff deflation, expected activity changes (based upon extrapolation of recent trends), developments, movements in non-patient income. This income assumption is clearly dependent on the success of demand management schemes especially in emergency care with further reductions in emergency activity anticipated.

Costs

The 2014/15 expenditure budget is fundamentally based upon the 2013/14 recurrent baseline adjusted to the 2014/15 price base and capacity levels aligning cost with activity, contracts and resources. This includes substantial investment in 2014/15 for; inflationary rises, volume allocations in respect of patient activity increases, historic cost pressures and service and capacity developments including the full year effect of 2013/14 schemes and is inclusive of reductions for cost improvement plans.

Budgets for 2014/15 are being developed with engagement from CSU management through the business planning process. The financial detail will be provided for budget holder sign off in due course. This will then form part of the 2014/15 performance management framework to assess delivery through the accountability meetings held with CSUs / Directorates.

Total inflationary increases from 2013/14 to 2014/15 of £5.3m have been identified and provided for. This funding can be split into two main categories, pay and non-pay. The former includes pay inflation at 1%, incremental drift based on the current staff profile, employer national insurance contribution increases and the recurrent impact of autoenrolement. The cumulative recurrent pay budget increase in 2014/15 is £2.8m. Additional stepped increases to medical staff discretionary and clinical excellence awards are also provided for separately. The provision for non-pay inflation is inclusive of CNST, PbR drug, rates and utility price increases with a standard 1% rise assumed across the remaining other non-pay expenditure categories. The cumulative recurrent non pay budget increase in 2014/15 is £2.5m.

The proposed 2014/15 volume funding allocation is built on adjusting expenditure budgets to fund delivery of 2013/14 outturn activity levels, in line with the activity now contracted for 2014/15. The main increase is in respect of non PbR drugs funding of circa £2.9m. The speciality detail will be provided to CSU managers as part of the budget sign off process. An assessment has also been made within the financial framework regarding the likely growth in activity in 2014/15, over and above that assumed in the contract settlements.

The proposed budget framework includes substantial investment in 2014/15 with the major elements being:

- Bed plan (inclusive of board ward) £5.4m
- Nursing Levels £1.3m
- 24/7 working £828k

The 7 day services expenditure plans include investment in Acute Medical, Federation and Care of the Elderly CSUs ward and medical cover at weekends and funding for clinical support CSUs to expand their service capacity. This funding will allow the Trust to achieve the key requirements for 7 day services set out by Keogh.

The outcome of the recent nursing level review suggests that with the scaling back of bed capacity outside of winter, the additional resources identified to support ward staffing will enable the Trust to make significant progress in this key area. It must be stressed again, however, that it is also anticipated that the impact of 7 day services, emergency pathway work, rehab pathway changes, community beds and enhanced ward staffing levels will reduce demand for beds, with bed retractions reducing the scale of staffing investment needed over the balance of the year and in the future.

The budget framework has also maintained a general contingency reserve of 1% (£3.5m recurrent funding) and established a development reserve of £2m (non-recurrent) to support in year cost pressures and developments.

Overall the above has contributed to an increase in expend budgets of 3.50% more than 2013/14 budgets (inclusive of reductions to deliver the 2014/15 efficiency programme).

Capital Plans

Capital expenditure of £19.2m in 2014/15 and £20.2m in 2015/16 is planned. This is less than the £21m forecast outturn for 2013/14, but remains higher than historic levels. The key areas of investment are:

- Medical Equipment – £7.9m over the next two years
- IT – £9.7m over the next two years
- Site Development – £19.5m over the next two years

The capital plans for the next two years are funded through a combination of:

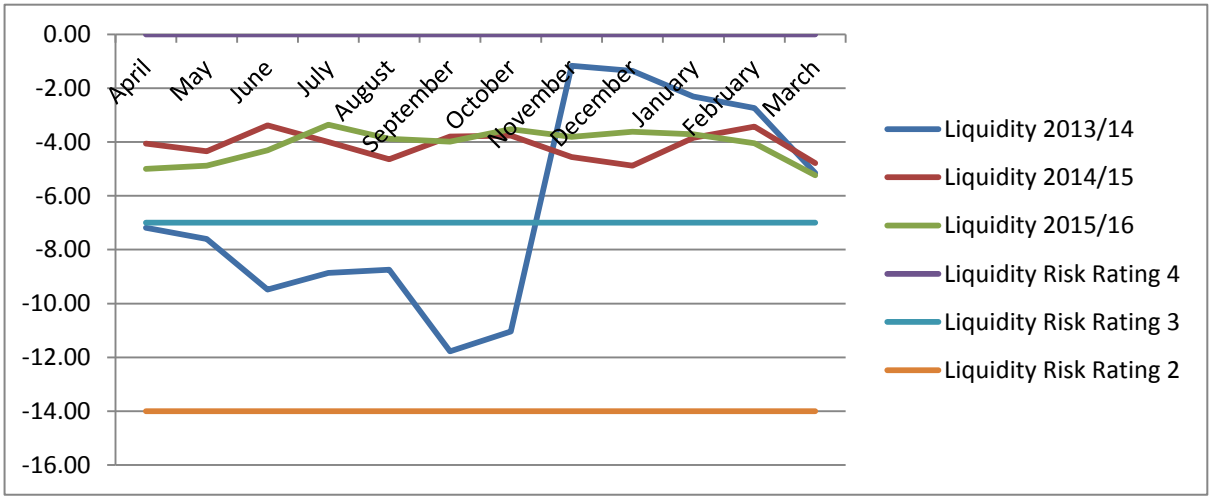
- Deprecation of £18.5m
- Funding carried forward from 2013/14 of £3.5m
- Safer Hospitals Fund of £5.0m to support IT investment
- Retained surplus of £5.7m
- Asset disposals of £1.2m
- Charitable funds of £1.7m

There is a potential need for external financing for the 2015/16 capital programme and this will be clarified once work on the site development plans for our major three sites has been completed early in the new financial year and alternative sources of funding have been fully explored.

Liquidity

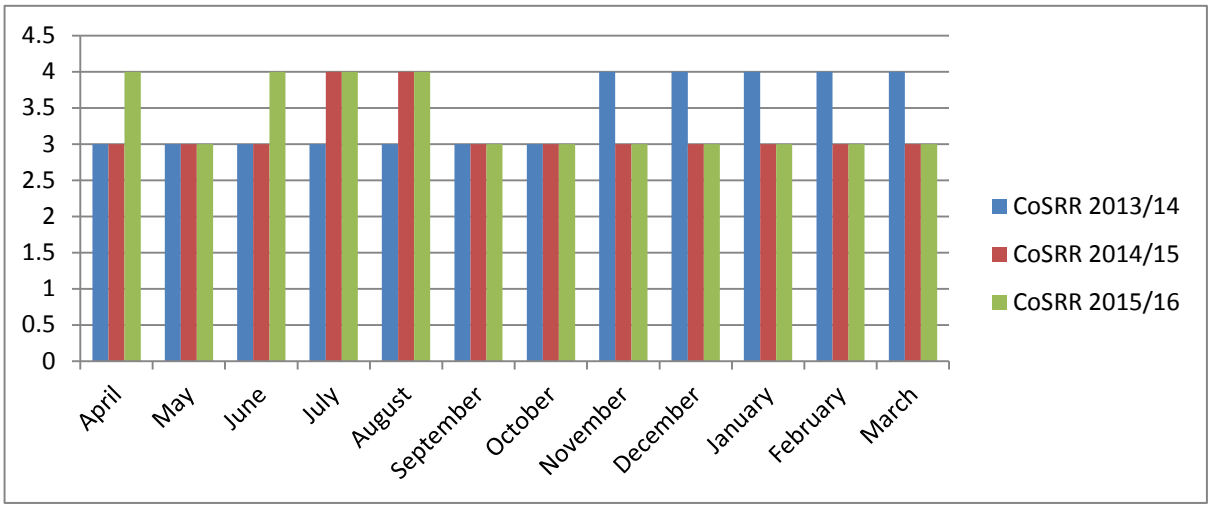
The Trust has improved liquidity in recent years and is keen to continue to do so. The liquidity plans include the drawing down of loans, from the Foundation Trust Financing Facility to support the overall liquidity position of £2.4m in 2014/15 and £2.0m in 2015/16.

The minimum month end cash balance over the 24 month period is £9.4m, with average trade debtor days of 13.9, with a maximum of 16.9 days; and average trade creditor days of 27.1, with a maximum of 29.8 days.



Risk Ratings

Continuity of Services Risk Ratings (CoSRRs) remain at a strong 3 throughout the planning period, with liquidity a stable 3 and the capital servicing ratio a strong 3, occasionally extending to a 4.



Downside Risks and Mitigation

Whilst the organisation will deliver its financial plan in 2013/14, there is significant ongoing financial risk given the general deterioration in NHS finances, the increasing financial challenges faced by our major commissioners and the need to make further efficiencies of 4-5% per annum throughout the planning period.

The key financial risks for next two years identified within the plan are:

1 – CSU/directorate overspending
2 – Delivery of the required savings
3 – Commissioner affordability / success of demand management

Key to the mitigation of a number of these risks is the quality of the plan, with, for example, the adequate funding of genuine cost pressures in CSUs, alignment of expenditure budgets with activity assumptions, 1% general contingency reserve, £2m in-year development reserve and sign off of budgets at Directorate level all key to mitigate the risk of CSU / directorate overspending.

Notwithstanding this, detailed work has been done to assess the impact of key financial metrics (operational surplus, cashflow and CoSRR rating) of each of the 3 key downside risks identified above. This is shown in the financial submission, alongside the impact of all 3 of these risks materialising concurrently (offset by the identified sources of mitigation). As can be seen, in each scenario CoSRR of 3 is maintained (albeit with significantly reduced headroom).